STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION AND PLAN O	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155752 A. BUILDING A. BUILDING	12/11/2012
B. WING STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 18325 BAILEY AVE	
MORNINGSIDE NURSING AND MEMORY CARE CENTER SOUTH BEND, IN 46637	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOW)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	
K0000	
A Life Safety Code Recertification K0000	
and State Licensure Survey was	
conducted by the Indiana State	
Department of Health in	
accordance with 42 CFR 483.70(a).	
G.,	
Survey Date: 12/11/12	
Facility Number: 004732	
Provider Number: 155752	
AIM Number: 200808300	
Surveyors: Joe L. Brown, Jr., Life	
Safety Code Specialist and Robert	
Sutton, Life Safety Code Specialist	
Trainee.	
At this Life Safety Code survey,	
Morningside Nursing and Memory	
Care Center was found not in	
compliance with Requirements for	
Participation in	
Medicare/Medicaid, 42 CFR	
Subpart 483.70(a), Life Safety from	
Fire and the 2000 edition of the	
National Fire Protection	
Association (NFPA) 101, Life	
Safety Code (LSC), Chapter 18,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

N1WP21

Facility ID:

TITLE

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752		LDING	NSTRUCTION 01	(X3) DATE COMPL 12/11/	ETED
	PROVIDER OR SUPPLIER	AND MEMORY CARE CENTER	D. WIN	18325 E	DDRESS, CITY, STATE, ZIP CODE BAILEY AVE BEND, IN 46637	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	New Health C 410 IAC 16.2.	are Occupancies and					
	construction a sprinklered. Talarm system in the corridor corridors, and smoke detectod 110, 111, and smoke detectod fourteen resident The facility has and had a censof this survey.	be of Type V (111) and was fully The facility has a fire with smoke detection s, areas opened to the battery operated rs in resident rooms 114 with hard wired rs in the other ent sleeping rooms. as a capacity of 40 sus of 35 at the time					
	customary acc All areas prov were sprinkler	re residents have ess were sprinklered. iding facility services red, except a wood hed which was 50					
	feet away fron	n the building.					
		Robert Booher, Life Safety dical Surveyor on 12/14/12.					
	The facility we compliance w	as found not in ith the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet

Page 2 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155752	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPI	
	PROVIDER OR SUPPLIEI	R AND MEMORY CARE CENTER	STREET . 18325	ADDRESS, CITY, STATE, ZIP BAILEY AVE I BEND, IN 46637	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	aforemention		TAG	DEFICIENCY		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet

Page 3 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION 01	(X3) DATE S COMPL		
11112 12111	155752			LDING		12/11/	
NAME OF B			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				BAILEY AVE		
	GSIDE NURSING A	AND MEMORY CARE CENTER		SOUTH	I BEND, IN 46637		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K0062 SS=E	NFPA 101 LIFE SAFETY CO Required automa continuously mair condition and are periodically. 18.7 NFPA 25, 9.7.5 Based on obse interview, the ensure 8 of 16 reisdent rooms maintained in condition. NF the Inspection Maintenance of Protection Sys states unaccep spray patterns NFPA 13, 199 for the Installa Systems, Secti sprinklers shall minimize obst as defined in 5 additional spri provided to en coverage of the deficient pract to affect the re-	DDE STANDARD tic sprinkler systems are ntained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, rivation and facility failed to sprinklers in eight s were continuously reliable operating PA 25, Standard for , Testing, and of Water-Based Fire stems, Section 2-2.1.1 table obstructions to shall be corrected. P9 Edition Standard ation of Sprinkler ion 5-8.5.1.1 states Il be located so as to ructions to discharge 5-8.5.2 and 5-8.5.3, or nklers shall be ssure adequate e hazard. This sice has the potential	K00		What corrective action will be accomplished for those residents foun to have been affected by the deficient practice: Rooms 101-108 will be fully protected by eith moving or changing the light fixture so that the sprinkler heads are no obstructed. How other residents having the potential be affected by the same practice will be identified and what	deereree ot	01/09/2013
	to affect the re	esidents in the			same practice will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet

Page 4 of 10

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED 12/11/2012		
		155752	B. WIN			12/11/	2012
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE		
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER			H BEND, IN 46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Findings inclu				be taken:		
	D 1 1				A 's all a d'Octable		
		ervation on 12/11/12			A visual audit of all		
		inistrator during the			sprinkler heads was		
		a.m. to 12:30 p.m.,			completed by the		
		s 101 through 108			administrator and		
	•	obstructed by the			rooms 102-115 was		
		xtures. Based on			found to require the		
		ng the time of			light fixtures to be eitl	ner	
		he Administrator			changed or moved.		
	acknowledged	I the sprinkler heads					
	in resident roo	oms 101 through 108			What measures will		
	were obstructe	ed by the ceiling			be put into place or		
	fixtures.				what systemic		
					changes will be mad	le	
	3.1-19(b)				to ensure that the		
					deficient practice		
					does no recur:		
					The facility does not		
					require any additiona	l	
					sprinkler heads to be		
					installed.		
					How the corrective		
					action will be		
					monitored to ensure		
					the deficient practice		
					will not recur, what	•	
					will flot recur, wilat		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/11/2012
	PROVIDER OR SUPPLIE	R AND MEMORY CARE CENTER	1832	T ADDRESS, CITY, STATE, ZIP CODE 5 BAILEY AVE TH BEND, IN 46637	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				quality assurance program will be put into place:	
				The administrator will be visually inspect all affected sprinkler heat to ensure they are not obstructed by light fixtures. If any obstructed sprinkler heads are found to be out of compliance the will be corrected immediately. The administrator will take any none-compliance the Q/A committee for one quarter. No additional Q/A reports will be necessary as administrator will have any issues corrected immediately. Completion Date: 1/9/2013	e e to er

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet

Page 6 of 10

STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	01	COMPL	ETED
	155752		B. WIN			12/11/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .		18325 E	BAILEY AVE		
MORNINGSIDE NURSING AND MEMORY CARE CENTER					I BEND, IN 46637		
(X4) ID	SUMMARY S'	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0074	NFPA 101						
SS=C	LIFE SAFETY CO	ns, including cubicle					
		er loosely hanging fabrics					
	and films serving	, , ,					
		alth care occupancies are					
		th provisions of 10.3.1 and					
		ards for the Installation of					
	accordance with	s. Shower curtains are in NFPA 701.					
	Newly introduced	upholstered furniture					
		e occupancies meets the					
		when tested in accordance					
	with the methods	cited in 10.3.2 (2) and					
	10.3.3. 18.7.5.	1, 1, NFPA 13					
		mattresses meet the					
		when tested in accordance					
	18.7.5.3	cited in 10.3.2 (3) , 10.3.4,					
		ation and interview, the	K00)74			12/12/2012
		ensure window curtains			K-74		
	in 17 of 17 resid	ent rooms were flame					
	retardant. This c	deficient practice could					
	affect all residen	ts, staff, and visitors.			What corrective		
					action will be		
	Findings include	: :			accomplished for		
					those residents foun	nd	
		ervation on 12/11/12			to have been affected	-	
	with the Admi	inistrator during the			by the deficient		
		a.m. to 12:30 p.m.,			practice:		
	documentation	n regarding flame					
		s not found on the			The administrator has	3	
	resident room	window curtains			visually inspected all	17	
	throughout the	e facility. Based on			rooms and they have		
	~	ne time of observation					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet

Page 7 of 10

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155752		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/11/2012	
	PROVIDER OR SUPPLIE	AND MEMORY CARE CENTER	18325	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE H BEND, IN 46637	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	no documenta	inistrator, there was ation regarding flame the window curtains		had their window curtains removed.	
	available for 1 3.1-19(b)			How other residents having the potential be affected by the same practice will be identified and what corrective action will be taken: No additional resident are affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does no recur: The administrator mut approve all window curtain purchases that must have a flame spread rating prior to purchase or all curtain	to e I ts

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet

Page 8 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN (T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	(X2) MULTIPLE CO A. BUILDING B. WING STREET	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 12/11/2012
	ROVIDER OR SUPPLIE GSIDE NURSING	AND MEMORY CARE CENTER		BAILEY AVE H BEND, IN 46637	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	will be treated with a flame spread rated spray of class B or above. How the corrective action will be monitored to ensure the deficient practic will not recur, what quality assurance program will be put into place: The administrator will maintain the documentation for the new curtains flame spread ratings or sprea	e e to or
				administrator will have any issues corrected immediately.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet Page 9 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 12/11/2012
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE	
MORNIN	GSIDE NURSING	AND MEMORY CARE CENTER	SOUTH	H BEND, IN 46637	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Completion Date: 12/12/2012	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N1WP21

Facility ID: 004732

If continuation sheet

Page 10 of 10